The Whole Child Associates, LLC

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**AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION**

Section A: Client complete for all authorizations. Please check and initial statement(s) that applies.

**[ ]** I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations. **Initials:_____**

**[ ]** I hereby authorize The Whole Child Associates to obtain individually identifiable health information as described below. I understand that this authorization is voluntary. Information obtained will be for the sole use of The Whole Child Associates to provide treatment, receive payment or for health care operation purposes.
**Initials:_____**

**Client Name:_____** **Date of Birth:_____**

The Whole Child Associates may release to or obtain form as indicated below (physicians, healthcare providers, educational programs, or other agencies) my health information.

**Name, Address, Phone, Fax**

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Description of information to be disclosed or obtained:

[ ] Evaluation/Assessment [ ] Progress Note/Summary [ ] Medical History

[ ] Discharge Reports [ ] Psychological Reports [ ] IEP/School Records

[ ] Medical Consultation [ ] Physical/Immunization Records

[ ] Other as here specified _____

**CLIENT or the CLIENT's REPRESENTATIVE READ AND INITIAL THE STATEMENTS:**

1. I understand that this authorization will expire within one year from today's date. **INTIALS:_____**

2. I understand that I may revoke this authorization at any time by notifying The Whole Child Associates in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions The Whole Child Associates took in reliance upon my authorization before it received my revocation.

**INTIALS:_____**

You may revoke this authorization by making a written request of Revocation of Authorization. Please address your Request for Revocation of Authorization to: The Whole Child Associates, 281 N. Willow Road, Elmhurst, IL 60126, Attn. Privacy & Security Officer.

3. The Whole Child Associates will not condition your treatment or payment for the health care services on your completing and signing this authorization.

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The Whole Child Associates personnel to complete for requests to obtain information:

1. The purpose of the use or disclosure is : [ ] Program Planning [ ] Other_____

2. The Whole Child Associates __will **X will_NOT** receive direct or indirect compensation in exchange for using or disclosing the information listed above.

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**MUST BE COMPLETED BY CLIENT OR CLIENT REPRESENTATIVE FOR ALL AUTHORIZATIONS.**

_____ _____

**Signature of Client or Client Representative** **Date**

_____ _____

**Client's Representative Name (Please Print)** **Relationship to Client**

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**